

General

Guideline Title

Practice parameter for psychodynamic psychotherapy with children.

Bibliographic Source(s)

Medicus J. Practice parameter for psychodynamic psychotherapy with children. *J Am Acad Child Adolesc Psychiatry*. 2012 May;51(5):541-57. [96 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Definitions of the strength of the empirical and/or clinical support ratings (CS, CG, OP, NE) are provided at the end of the "Major Recommendations" field.

Note: Unless otherwise noted, the term "parents" refers to the child's primary caregivers, irrespective of their biological relationship to the child.

Recommendation 1. Psychodynamic psychotherapy requires training in psychodynamic theory and techniques. [CS]

The therapist should be knowledgeable regarding child development and acquainted with the range of psychodynamic theories (e.g., ego psychology, object relations theory, attachment theory, and self psychology). Clinical experience should be acquired under supervision. Optimally the training experience should include children of both sexes in various developmental phases and with various psychopathologies.

The clinician tailors the psychodynamic psychotherapy to the individual patient through flexible application of generic psychodynamic principles and selection of psychodynamic techniques based on a developmentally informed, biopsychosocial formulation of the case.

Recommendation 2. The clinician should understand the full spectrum of psychodynamic therapeutic interventions, from supportive to expressive modalities. [CG]

Traditionally psychodynamic psychotherapies have been conceptualized as extending along a spectrum from supportive to expressive. The more supportive therapeutic interventions are those that are meant to build on the patient's strengths and existing psychological capacities either through a positive relationship with the therapist or through therapeutic interventions, such as encouragement, suggestions, and education, that facilitate the development of adaptive capacity. The adaptive capacities affected are impulse control; tolerance for frustration, anxiety, and affect; capacity to anticipate, reflect, or subliminate; and communication through play or language. The expressive therapeutic interventions address the child's

unconscious conflicts, traumatic memories, feelings, maladaptive defense mechanisms, and distortions of the relationship with the therapist (transference). The repetition of past experiences allows them to become conscious, so that their pathological residues can be worked through and resolved.

Recommendation 3. The therapist is informed about indications and contraindications for psychodynamic psychotherapy. [CS]

The use of psychodynamic psychotherapy is not diagnosis specific. It has been used effectively for internalizing disorders, externalizing disorders in the mild to moderate spectrum of severity, developmental character difficulties and maladaptive, internal responses to life events. In addition to diagnosis, consideration must be given to the child's ability to work with the therapist toward self-understanding. Psychodynamic psychotherapy is helpful in complex cases because it addresses the underlying psychological functions.

Brief, time-limited, individual psychotherapy is indicated with children who are in acute, situational distress such as grief, separation anxiety, sleep problems, or acute anxiety. There is an agreed-upon focus of treatment and an agreed-upon point of termination, which brings momentum to the process. The treatment goals aim at increasing adaptive behaviors, gaining symptomatic improvement, and enhancing adaptation to family, school, and peers.

Long-term, open-ended psychotherapy is indicated when the biological or social factors destabilizing the child's adaptation and development are chronic, or the psychological difficulties due to comorbidities are complex, or entrenched conflicts and developmental interferences are present. In addition to the goals sought in brief therapy, long-term psychodynamic psychotherapy aims at redressing maladaptive personality traits, reworking conflicts to relieve constricting defensive and relational patterns, lifting of unnecessary inhibitions, development of flexible thinking and access to fantasy life. It stabilizes psychological functioning by increasing freedom of expression through play and words rather than through impulsive actions. It develops the flexible use of defenses and age-appropriate assessment of realities of the child's life. It enhances the capacity for pro-social activities, age-appropriate autonomous functioning in school, and an age-appropriate sense of identity including sexuality and positive self-regard.

For severely organically impaired children, those with significant mental retardation, psychosis, or severe pervasive developmental disorders and for severe conduct disorder without guilt or remorse, expressive psychodynamic psychotherapy is usually contraindicated. In contrast, supportive psychodynamic psychotherapy can be usefully tailored to each of these conditions.

Recommendation 4. The therapist is informed about potential complications and adverse effects of psychodynamic psychotherapy. [CS]

In some instances there may be transitory deteriorations (regressions) in the level of functioning, such as acting-out behaviors or exacerbation of parent-child conflict. In addition complications may arise in the relationship between the parents and the therapist. Common examples include excessive dependence of the parents on the therapist, and threats of treatment disruption if the parents feel criticized by the therapist or resent the therapist's close relationship with the child. In very difficult cases consultation with a colleague can be beneficial to the therapist. Additionally, obtaining a second opinion can be useful in difficult cases.

Recommendation 5. When indicated, the clinician will combine individual psychodynamic psychotherapy with other treatments such as group therapy, family therapy or psychopharmacology. [CG]

The psychodynamic psychotherapist, working within a biopsychosocial model, may recommend treatments in addition to the individual therapy. Group psychotherapy may be appropriate for addressing difficulties with peer relationships. Family therapy may be indicated to address family dysfunction.

Medication may be used adjunctively to relieve symptoms and facilitate the patient's ability to work in therapy. The therapist must take into account the possible meanings that the child or the family may assign to taking medication. Medication and psychotherapy may require different amounts of time to reach their respective maximum effectiveness. Medication may target the symptoms while the psychotherapy is aimed at facilitating the resumption of healthy character development. If the medication is effective in relieving symptoms, the problem arises that whenever symptoms are relieved some parents may be tempted to discontinue the treatment before underlying issues are resolved in psychotherapy. Nonadherence with medication due to fear of drug addiction or fear for the child's safety can best be addressed through the therapist's collaborative alliance with the parents.

Recommendation 6. The clinician formulates a psychodynamic understanding of the child and family and communicates it to the family within the context of a biopsychosocial treatment plan. [CG]

Formulation is the process by which the clinician organizes the clinical data obtained from the evaluation and the ongoing work with the patient and caregivers. The formulation gathers together the biological information about the child (e.g., genetics and epigenetic influences, temperament, physical development and intelligence), the psychological data (e.g., developmental history, emotional development, personality style, self-esteem, conscience, theory of mind, defenses and coping skills, object representations and relational patterns and evidence of internal conflicts) and

sociological information (e.g., assessment of the family and the child's place in it, peer relations, school functioning, cultural and spiritual traditions).

The psychodynamic psychotherapist uses psychoanalytic theory (e.g., ego psychology, object relations theory, attachment theory, self psychology, and developmental theory) to relate the biopsychosocial data to the presenting symptoms and the diagnosis. Diagnosis may be both a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis and a Psychodynamic Diagnostic Manual (PDM) Diagnosis. The psychodynamic therapist considers the precipitating events that brought the child to treatment at this time in the context of developmental theory asking "what developmental challenge may have precipitated the child's symptoms at this time?"

Once the therapist has integrated the available information into a psychodynamic understanding of the patient's condition the therapist turns to the treatment planning aspect of formulation. Considering the severity of the patient's difficulties, the impact on the child's development, and the patient's and family's strengths and weaknesses, the therapist gauges the child's needs in terms of frequency of sessions for both the child and the parents and the duration of treatment. The formulation guides the therapist's recommendations of other treatment modalities. The therapist must translate the formulation and recommendations into terms the parents can understand and, when speaking to the child, in terms appropriate to the child's development and capacity to understand.

Recommendation 7. The clinician establishes a therapeutic alliance with the child based on respect for the child's autonomy, developmental state, defensive style, and specific pathology, and attends to all aspects of the patient's communications: verbal, gestural, and symbolic (play). [CG]

The therapeutic partnership is built on respect for the child. The maintenance of confidentiality and respect for the child's autonomy, exemplified through the therapist's ability to listen to the point of view of the child, creates a safe therapeutic space. The therapist's attunement to the child's developmental status and defensive structures is also essential to the alliance.

Recommendation 8. The therapist must maintain patient confidentiality and a commitment to keeping the child's specific communications private. [CS]

Confidentiality is crucial for psychodynamic psychotherapy. The clinician must skillfully communicate dynamic understanding to parents or collaborating clinicians while protecting the child's confidential communications. The child's communications are confidential unless in the therapist's judgment they indicate potential danger to the child, to others, or to property, or the child gives permission to share the child's specific communications with the parents *and the therapist agrees*. The therapist tells the child when and what information will be shared with the parents. The parents' reports about the child or family are shared with the child when the therapist thinks it useful to do so. The therapist may become aware of a family secret or taboo. This awareness may come from the child or from the parents. The therapist must use good clinical judgment in choosing if, when, how and to whom to disclose this information.

Recommendation 9. The clinician establishes an ongoing collaborative alliance with the family through which they participate as partners in the treatment. [CS]

In the collaborative alliance with the parents, the therapist must strive to maintain neutrality and not side with the parents against the child or with the child against the parents. The therapist's attitude and behavior needs to be reliable, knowledgeable, and professional. The parents' cultural and family traditions, personal style, and values should be respectfully taken under consideration.

Exchange of Information: The therapist gives information concerning the general progress of therapy without giving the specific communications of the child. The therapist discusses the course of treatment and any recommendation for additional treatment modalities. Ideally the parents will inform the therapist of changes in family circumstances and provide updates on the child's life and behavior outside the treatment setting. The therapist should avoid allowing parents to use time scheduled for the child for parent-therapist information exchange. Parent communications about the child that are made in front of the child should be limited to brief, socially appropriate exchanges of greetings in the waiting room. Occasionally the child may express a wish to bring a member of the family, friend or even a pet to the session. The therapist will use clinical judgment in determining when such inclusion will further the therapy. At other times the clinician may feel it is clinically advantageous to meet with the parent and child together. In these cases care must be taken to maintain the therapist's primary alliance and allegiance with the child.

Addressing Parents' Negative Feelings: Parents may have negative feelings about the treatment, the therapist, or the child. The roots of negative feelings are varied and include parental self-devaluation, parental competition with the therapist, or disappointment due to unrealistic expectations of the therapist or the child. The clinician must be alert for times when the child, stimulated by difficult work in the treatment, complains to the parents or in other ways generates negative feelings in the parents about the treatment.

It is important to address negative parental feelings in order to limit parental undermining of the treatment or premature termination.

Parent Education: The therapist supports parental curiosity about the child's developmental needs, individual characteristics, and subjective experience to facilitate their parenting. The therapist supports the parents' striving to establish realistic social and academic goals for their child.

Parent Counseling: At times it is clear to the therapist that a parent's own psychological difficulties interfere with the child's progress. In this difficult situation the therapist must use clinical judgment to determine whether the parent may be referred for his or her own therapy. When the parent cannot be referred the therapist must be careful not to be the individual therapist for both the parent and the child.

Recommendation 10. The therapist should collaborate with other professionals in the treatment of the child. [CS]

With the assent and consent of the child and parents, the therapist will collaborate with other professionals involved in the case when it is appropriate. Keeping the child's confidentiality, the therapist clarifies to other professionals the child's characteristics, ways of perceiving and reacting to situations, particular ways of responding to and communicating with others, and developmental challenges.

Recommendation 11. The clinician is knowledgeable about play and skillful at using it in the therapeutic situation. [CG]

For most children, play is a primary way of expressing feelings, impulses, fantasies, and conflicts. One study noted that "play is the child's form of the human ability to deal with experience by creating model situations and to master reality by experimentation." In supportive psychotherapies, play is frequently a goal in itself because of its intrinsic development-promoting functions. In more expressive psychotherapies, play serves as a background activity, enabling the child to communicate verbally with the therapist. A comprehensive review of the psychological functions of play is beyond the scope of this parameter but can be found in the extensive literature on play and development.

Children's activities in a play therapy tend to fall into the following categories: physical activities, solo imaginary play games with rules, creative projects, and imaginary play with the therapist as a participant. The play therapy office must be suitably sturdy and equipped in a manner age-appropriate to the children who will be treated there. When working with young children who are struggling to control intensely messy or aggressive impulses a separate playroom is advantageous. The issue of limit setting will arise no matter how appropriately the office or playroom is outfitted. Common-sense limitations are necessary to protect the room, therapist, and child from physical damage. One way to understand the limits is to say, "When we are done I have to be able to clean up and have you, me, and the office/playroom back the way it was." The toys do not need to be numerous or elaborate. Having too many toys in the playroom can be problematic, e.g. overstimulating. It is helpful to have a deck of cards, one or two simple board games such as checkers or Trouble, a Nerf or koosh ball, paper, art supplies, a set of blocks, puppets, action figures, and dolls or animal figures. A family grouping of animals or small dolls is useful. The child can use a ferocious animal (e.g., shark, lion, or dinosaur) to express aggressive urges.

The psychodynamic play therapist develops skill at playing with the child while attending to both the content, and most importantly, the process of the play. Thus when playing a board game the therapist is keenly interested in how the child plays and what this manner of play reveals about the child's inner conflicts and relational patterns. Additionally, the therapist is attuned to the flow of the play as a marker of the child's inner state. Does the child reach a satisfying conclusion or are there compulsive repetitions, disruptions, or interruptions?

The therapist must be skilled at timing interventions, particularly interpretative interventions, so as not to inhibit or distort the play. The therapist is skilled at making the interventions covered below under Recommendation 12 in the context of the child's play. In expressive psychotherapy, the symbolic meanings of play are interpreted to enable the child to have contact with his/her feelings, unconscious motives, defenses, and wishes. The therapist needs to be skilled at using the play metaphor to make verbal interventions more tolerable to the child (e.g., the therapist says "the daddy doll" not "your daddy"). This use of the metaphor created by the play is called *working in the displacement*. When the child gives the therapist a role in the play frequently the child will create role reversals (e.g., having the therapist play the student while the child plays the teacher). This is called *turning passive to active*. The therapist needs to be skilled at enacting and commenting on the feelings and conflicts in the "child role."

Recommendation 12. The clinician is skillful in the use of the spectrum of psychodynamic verbal interventions. [CG]

1. *Ordinary Social Behavior.* Socially appropriate verbal interventions (such as conventional expression of greeting and leave-taking) are primarily supportive.
2. *Statements or Questions Relating to Treatment.* These supportive interventions convey direct information about the framework of the therapy. The therapist gives information about the structure of sessions, the behavioral limits within sessions, the therapist's role, and any other matters that need clarification.
3. *Statements or Questions Relating to the Child's Life.* The therapist asks the child for objective information in order to fill in biographical data. This request conveys to the child that he/she is an important source of information and focus of interest to the listening therapist. However, the therapist should respect a child's reticence or resistance and not become an interrogator.

In most psychodynamic psychotherapies the therapist will use a combination of supportive and expressive interventions (see Recommendation 2). The more expressive interventions require the child to be closer to feelings, urges, and thoughts that the child may find painful or overwhelming. Whether the therapist chooses expressive or supportive interventions depends on the therapist's assessment of the child's *ego strength*. Ego strength reflects the degree to which the child has acquired psychological capacities appropriate to the child's developmental status. Such capacities include intelligence, psychological mindedness, age-appropriate reality testing, capacity for impulse

control, tolerance for frustration, and the ability to manage affects. Children with good ego strength benefit from expressive therapy. In contrast, children with low ego strength benefit more from supportive, developmentally-assistive therapy.

Thus we have a continuum of verbal interventions beginning with those addressed to the conscious level, moving to interventions addressed to preconscious contents (i.e., contents that are accessible if attention is focused on them), and continuing on to interventions aimed at unconscious contents (i.e., contents not easily accessible to the child's awareness). The following interventions can be made directly or within the play metaphor.

4. *Supportive Interventions.* Supportive interventions include educational statements, suggestions, or expressions of encouragement, reassurance, and empathy.
5. *Facilitative Statements.* Through facilitative interventions the therapist initiates, enhances, or maintains the exchange with the child either through invitations to continue his/her communications or by reviewing what has transpired in the session or in previous sessions.
 - a. Invitations to continue convey the therapist's emotional availability and ongoing interest. They also encourage the child to verbalize experiences and events in the session. Invitations to continue can be open-ended, or the therapist may choose a particular topic from the child's conversation and request expansion or additional information on that specific topic.
 - b. In review statements the therapist paraphrases, summarizes, or integrates what the child has said or done. By mirroring back the child's experience, the therapist's verbalizations confirm and validate the child's subjective experience, model self-observation and sequential thinking, and support the integrative functions of the child's mind.
6. *Clarifications.* Through clarification the therapist expands the child's awareness into the preconscious realm (i.e., what is knowable if attention is focused on the particular topic). Clarifications consist of preparatory statements and "look at" statements.
 - a. Preparatory statements focus the child's attention on the possibility of new meanings in his/her comments, affects, play, and nonverbal behaviors. The statement alerts the child to what is going on and that there may be other meanings to be discovered. The therapist provides a stimulus for self-observation and self-assessment. Subsequent interventions provide opportunities for the child to identify with the therapist's function, strengthening the child's ego so that the child acquires the capacity to observe, assess, and reflect on his/her experience.
 - b. "Look at" statements specifically identify and direct the child's attention to affects, thoughts, behaviors, or play occurring within the session. These clarifications engage the child's observing ego, enhancing self-awareness. "Look at" statements can also be applied to the child's past and to previous sessions. In this way the therapist supports memory-sequencing, helping the child to integrate experiences in space and time and maintain a sense of continuity. These interactions enhance the child's feeling of being understood by the therapist. Moreover, by observing the spectrum of his/her behaviors, the child can anticipate his/her emotional reactions and potentially choose more adaptive responses, thus developing a capacity to reflect before acting.
7. *Confrontations.* This verbal intervention addresses content that is not easily retrievable—the unconscious. Confrontations involve "see the pattern" statements. The therapist identifies patterns or sequences in events, affects, behavior, or ideas that, once pointed out, permit the child to see connections between apparently disparate behaviors or events. For example, a therapist might say directly, "Have you noticed that your stomachaches almost never happen on weekends or holidays?" or "Every time we talk about me, you change the subject." Or the therapist might point out, speaking within the metaphor of the play, "No matter how many gifts the dolly gets, she's always unhappy." These interventions serve the purpose of integration and mastery by making the child aware of unconscious elements that influence his/her affects, behaviors, or ideas. This awareness helps the child develop more adaptive responses to internal conflicts.
8. *Interpretations.* Through interpretations the therapist proposes links between the behaviors, feelings, and ideas that the child is aware of and the child's unconscious (a) defenses, (b) wishes, (c) past experiences, or (d) dreams. As children become acquainted with the ways they protect themselves from unacceptable thoughts, feelings, and behaviors, they gain self-understanding and view their experiences as something within their control. They are then open to the possibility of using other, more mature and adaptive, coping mechanisms.
 - a. Defenses. The interpretation of primitive, maladaptive defenses can be made when the therapist assesses that the child is capable of moving to a more mature defense to manage the unacceptable thoughts and feelings the defense has covered. (See Table I in the original guideline document.) It is important to address the defense (especially against painful affects) first before bringing the child's attention to the unacceptable thoughts or feelings. The therapist uses a narrative to describe how the child uses the defense in play or conversation with the therapist. For example, the therapist might say, "You wish you could be king of the world because then you would be the boss of everybody and you think no one could do anything that would hurt you, but in that way it's much harder to get along with other kids." That statement addresses the child's use of omnipotent control. The pros and cons of the defensive strategy are thus clarified.
 - b. Wishes. Through interpretations of wishes hidden in the child's play or statements, the child learns that unrecognized assumptions or urges may underlie behavior. For example, the therapist might observe, "When you get scared you'll never have enough, that's when you eat up all the cookies." Or "You wish you were my baby because you think then you could stay here with me." Or "The little girl doll wished her mother would take a trip so she and her daddy could stay home together, just the two of them." Thus the therapist

makes the wishes conscious and shared between them. Together they can measure it against reality and find socially acceptable compromises for satisfying the wish.

- c. Past Experiences. Interpretations referring to experiences from earlier in childhood permit the child to rework sequestered affects, beliefs and defenses of that earlier period with the child's current, more developed, psychological capacities. The effective use of these interpretations—also called "constructions" and "reconstructions"—depends on the degree of evidence available about the child's early childhood experiences and their possible impact on the present. For example, a therapist might say, "When you keep playing the 'falling off the table' game, I think you're playing what you think happened to mommy when she got hurt;" or "You've been afraid that your mean wishes may come true ever since your baby brother died . . . that's why you got so scared when you wished I'd get sick and the next day I had a bad cold."
- d. Dreams. The therapist understands the manifest content of the child's dream, the dream story, in the context of the child's life situation and internalized conflicts. Dream interpretations should be made working from the child's conscious associations to the dream and its relation to the child's waking awareness to elements in the dream that may reflect of the child's internal conflicts. Dream interpretations provide continuity between what the child is thinking while sleeping and what the child is thinking while awake, thus integrating the child's sense of self. The translation of dream content (primary process thinking) into logical thinking (secondary process) is supportive, especially for children who have nightmares or problems in their relationship to reality. For example, the therapist might say, "Those monsters are your own fears that you put in the dream. Let's draw them and get rid of them by putting them into the garbage can." In expressive psychotherapy the child may be encouraged to say what pops into his/her mind about a dream in order to understand its hidden or latent meaning.

Mode of Intervention

Also important to effective verbal intervention is the mode in which the therapist expresses the intervention.

- a. In the *direct mode* the therapist refers to the child's immediate appearance or behavior—"You look upset today."
- b. In the *therapist-related mode* the therapist refers to the child's perceptions of the therapist in terms of the transferences of past relationships that the child has begun to reenact with the therapist—"I believe you are seeing me as a police officer who is going to punish you or as a daddy who is very strict."
- c. In the *indirect mode* the therapist refers to the child's behavior, thoughts, and feelings through the metaphors of play, role-taking, or other people or characters. For example: "It looks like the cowboy doesn't expect he will win against the Indians; what could he do?"
- d. In the *therapist's perspective mode* the therapist reflects out loud on his/her own thoughts and feelings, encouraging the child to take into account the therapist's different perspective of what is going on without imposing it on the child. By using this mode, the therapist protects the self-esteem of the child, who may feel easily criticized and turn a deaf ear to the therapist's comments. For example: The therapist is playing Monopoly™ with the child, who is cheating by taking extra properties without paying. The therapist says to himself/herself, "If I were a kid his age I wouldn't play with him anymore. It makes me mad." The child grins, as if he finally found out why other children do not want to play with him.

Recommendation 13. The clinician is skillful in monitoring change during the course of treatment and assessing readiness for termination. [CG]

Symptom reduction, achievement of normal development, age appropriate autonomy and self-reliance are indicators of readiness for terminations of psychotherapy. These changes are not limited to the therapy setting but extend to home and community. A child may appear better outside the sessions than within the sessions, or vice versa. To consider termination, improvement should be present in both domains. Finally, the child's capacity "to reflect on his own and others' mental states as indicated by his ability to understand, predict and plan for his own and others' responses" represents a measure of resilience. Scales of particular relevance to the psychodynamic clinician are now available. These include *Perceptions of Friendships and Peer Relations*. They enable the therapist to articulate the nature and extent of changes in the child's overall functioning in addition to symptom improvement. The scales are consistent with the objectives of psychodynamic therapy and are more likely to reflect its effects. Criteria observed within the sessions that support ending treatment are described by one of the authors. Additionally clinicians use widely disseminated clinical scales such as the Global Assessment of Functioning Scale.

Parents' readiness for concluding the child's treatment must also be assessed. Parents may react intensely in positive or negative ways to termination of their child's therapy. Parents need their own opportunity to elaborate on the loss of their relationship to the therapist.

Countertransference risks during termination are frequent. The therapist may experience a compelling wish to become an informal friend of the child. The therapist may be tempted to prolong treatment if the patient becomes "the ideal patient." The therapist may misinterpret adolescent interruption of treatment as an adolescent search for independence. The therapist may feel defensive in the face of parental disillusionment if all treatment goals have not been achieved.

Recommendation 14. The therapist must maintain objectivity and an attitude of consistency and realistic hopefulness and neutrality. [CS]

The therapist's empathy needs to extend to each member of the family, without taking sides, so that the child does not feel scapegoated and the parents do not feel criticized by the therapist.

The therapist's capacity to maintain objectivity depends on his/her ability to be aware and keep separate his/her own personal issues. Moreover, the therapist has to be aware of how patients or parents' transferences to the therapist may elicit reactions in the therapist that may contribute to the loss of objectivity in the case. Self-reflection and consultation enable the therapist to regain objectivity.

Definitions:

Strength of the Empirical and/or Clinical Support

- Clinical Standard [CS] is applied to recommendations that are based on rigorous empirical evidence (e.g., meta-analyses, systematic reviews, individual randomized controlled trials) and/or overwhelming clinical consensus.
- Clinical Guideline [CG] is applied to recommendations that are based on strong empirical evidence (e.g., non-randomized controlled trials, cohort studies, case-control studies) and/or strong clinical consensus.
- Option [OP] is applied to recommendations that are based on emerging empirical evidence (e.g., uncontrolled trials or case series/reports) or clinical opinion, but lack strong empirical evidence and/or strong clinical consensus.
- Not Endorsed [NE] is applied to practices that are known to be ineffective or contraindicated.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Mental health disorders including (but not limited to):

- Anxiety
- Depression
- Post-traumatic stress disorder
- Internalizing disorders
- Externalizing disorders
- Developmental character difficulties
- Maladaptive, internal responses to life events
- Sleep disorders

Guideline Category

Management

Treatment

Clinical Specialty

Pediatrics

Psychiatry

Psychology

Intended Users

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Guideline Objective(s)

To provide evidence-based research data supporting the effectiveness of psychodynamic psychotherapy for children

Target Population

Children ages 3 to 12

Interventions and Practices Considered

1. Psychodynamic psychotherapy
2. Combined psychodynamic psychotherapy (with group therapy, family therapy, or psychopharmacology)
3. Biopsychosocial treatment plan
4. Establishment of a therapeutic alliance with patient
5. Maintenance of patient confidentiality
6. Establishment of an ongoing collaborative alliance with patient's family
7. Collaboration with other professionals
8. Play therapy
9. Psychodynamic verbal interventions
10. Monitoring change and readiness for termination of therapy

Major Outcomes Considered

- Change in psychopathological symptoms, including ability to form close personal relationships, ability to play normally, and ability to communicate
- Change in mean scores measuring attention, delinquency, and aggressiveness
- Change in development and management of comorbidities
- Change in use of mental health services
- Duration of therapy based on condition being treated

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The literature search was conducted in October 2011 using MEDLINE, EBM Reviews (evidence-based medicine), PubMed, PsycINFO, ERIC (education), Social Work Abstracts, and PEP-WEB (psychoanalytic electronic publications). The search in MEDLINE combined the search terms: "child" OR "youth" AND "psychodynamic psychotherapy" OR "psychoanalytic psychotherapy" OR "psychoanalysis" yielding 10454 results which totaled 7530 when the search was limited to English language. These results were further limited to "human", child (2-12 years), "review

articles" yielding 47 results. When limited to "core clinical journals", 2 results were retrieved. The search was repeated in PsycINFO and yielded 56159 results which totaled 41395 when the search was limited to English language. These results were then limited to "human", "child (2-12 years)", "peer reviewed articles" yielding 518 results. When limited to "reviews", 2 results were produced. The search was repeated in the EBM Reviews (evidence-based medicine database) resulting in 0 articles, in ERIC (education) yielding 119 results and in Social Work Abstracts yielding 82 results. The PEP-WEB (psychoanalytic electronic publications) was searched in English language for "child" AND "psychodynamic psychotherapy" or "psychoanalytic psychotherapy" or "psychoanalysis" resulting in 603 results. These results were further limited to "articles" yielding 485 results and to the Psychoanalytic Study of the Child producing 13 results.

The PubMed database was searched independently to benefit from the use of the MeSH term database. In PubMed, MeSH terms were used to narrow the search results. The MeSH term "psychodynamic psychotherapy" was used, and the results were limited to "children (3-12 years)", "human" and "English" yielding 140 results. When those were limited further, 1 result was found for "meta-analyses," 6 for "randomized controlled trials," 25 for "reviews" and 0 for "practice guidelines." Continuing in PubMed, a search using the MeSH term "psychotherapy" yielded 346 results when restricted to "children (3-12 years)". When the results were limited to "English," "meta-analyses," "randomized controlled trials," and "reviews and practice guidelines", 46 results were identified (5 randomized controlled trials [rcts] and 41 reviews). The same search for the MESH term "psychoanalysis," limited to children from age 3-12 years, yielded 524 results. When the results were limited to "English," "meta-analyses," "randomized controlled trials," and "reviews and practice guidelines," 51 results were identified (51 reviews).

The PsycINFO database was searched independently for the benefit of the specific subject headings used in the database. In PsycINFO the "psychodynamic psychotherapy" or "psychoanalysis" subject headings were combined with the subject heading of "mental health disorders" and limited to "English," "human" and "children (2-12 years)," yielding 8 results. The subject headings "psychodynamic psychotherapy" or "psychoanalysis" AND "psychotherapeutic processes" were combined, and yielded 572 results using the same limits. The subject headings "psychodynamic psychotherapy" or "psychoanalysis" AND "treatment termination" yielded 44 results when limited to the 2-12 years old population.

Abstracts selected from the searches were studied to select material for the parameter. The reference sections of review articles were searched for material not included in the search. The review articles that addressed psychodynamic psychotherapy or psychodynamic psychotherapy were initially reviewed. In addition, topics addressing indications and clinical processes including termination and work with parents were examined.

Individual child psychodynamic psychotherapy for 3-12 year old children was the specific basis for consideration in the literature review. Some interventions historically developed for psychoanalytic treatments were included based on their application in the psychodynamic psychotherapy context.

Number of Source Documents

See the "Description of Methods Used to Collect/Select the Evidence" field for the number of documents retrieved from each database searched.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

The strength of the empirical evidence is rated in descending order as follows:

- (rct) Randomized, controlled trial is applied to studies in which subjects are randomly assigned to two or more treatment conditions
- (ct) Controlled trial is applied to studies in which subjects are non-randomly assigned to two or more treatment conditions
- (ut) Uncontrolled trial is applied to studies in which subjects are assigned to one treatment condition
- (cs) Case series/report is applied to a case series or a case report

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

The strength of the empirical evidence is rated in descending order (see the "Rating Scheme for the Strength of Evidence" field).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed by the AACAP Committee on Quality Issues (CQI) in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP Web site. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

The AACAP develops both patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on clinical consensus. This Parameter is a patient-oriented Parameter.

Rating Scheme for the Strength of the Recommendations

Recommendations for best assessment and treatment practices are stated in accordance with the strength of the underlying empirical and/or clinical support, as follows:

- Clinical Standard [CS] is applied to recommendations that are based on rigorous empirical evidence (e.g., meta-analyses, systematic reviews, individual randomized controlled trials) and/or overwhelming clinical consensus.
- Clinical Guideline [CG] is applied to recommendations that are based on strong empirical evidence (e.g., non-randomized controlled trials, cohort studies, case-control studies) and/or strong clinical consensus.
- Option [OP] is applied to recommendations that are based on emerging empirical evidence (e.g., uncontrolled trials or case series/reports) or clinical opinion, but lack strong empirical evidence and/or strong clinical consensus.
- Not Endorsed [NE] is applied to practices that are known to be ineffective or contraindicated.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This Practice Parameter was reviewed at the Member Forum at the American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting in October 2005.

From July 2006 to November 2011, this Parameter was reviewed by a Consensus Group convened by the Committee on Quality Issues (CQI).

This Practice Parameter was approved by the AACAP Council on January 24, 2012.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate use of psychodynamic psychotherapy to improve the ability of the child to function at home, in school and in the community

Potential Harms

In some instances there may be transitory deteriorations (regressions) in the level of functioning, such as acting-out behaviors or exacerbation of parent-child conflict. In addition complications may arise in the relationship between the parents and the therapist. Common examples include excessive dependence of the parents on the therapist, and threats of treatment disruption if the parents feel criticized by the therapist or resent the therapist's close relationship with the child.

Contraindications

Contraindications

For severely organically impaired children, those with significant mental retardation, psychosis, or severe pervasive developmental disorders and for severe conduct disorder without guilt or remorse, expressive psychodynamic psychotherapy is usually contraindicated. In contrast, supportive psychodynamic psychotherapy can be usefully tailored to each of these conditions.

Qualifying Statements

Qualifying Statements

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed to assist clinicians in psychiatric decision-making. These parameters are not intended to define the sole standard of care. As such, the parameters should not be deemed inclusive of all proper methods of care nor exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Medicus J. Practice parameter for psychodynamic psychotherapy with children. J Am Acad Child Adolesc Psychiatry. 2012 May;51(5):541-57. [96 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

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Guideline Developer(s)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

Source(s) of Funding

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Guideline Committee

American Academy of Child and Adolescent Psychiatry Committee on Quality Issues (CQI)

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Financial Disclosures/Conflicts of Interest

Drs. Kernberg, Ritvo, and Keable have no financial relationships to disclose. Oscar Bukstein, M.D., M.P.H., co-chair, receives or has received research support, acted as a consultant and/or served on a speaker's bureau for McNeil Pediatrics, and Novartis Pharmaceuticals Corporation. Heather Walter, M.D., M.P.H., and William Bernet, M.D., co-chairs, have no financial relationships to disclose. Disclosures of potential conflicts of interest for all other individuals are provided on the American Academy of Child and Adolescent Psychiatry (AACAP) Web site on the [Practice Parameters page](#) .

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the [American Academy of Child and Adolescent Psychiatry \(AACAP\) Web site](#) .

Availability of Companion Documents

None available

Patient Resources

None available

NGC Status

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